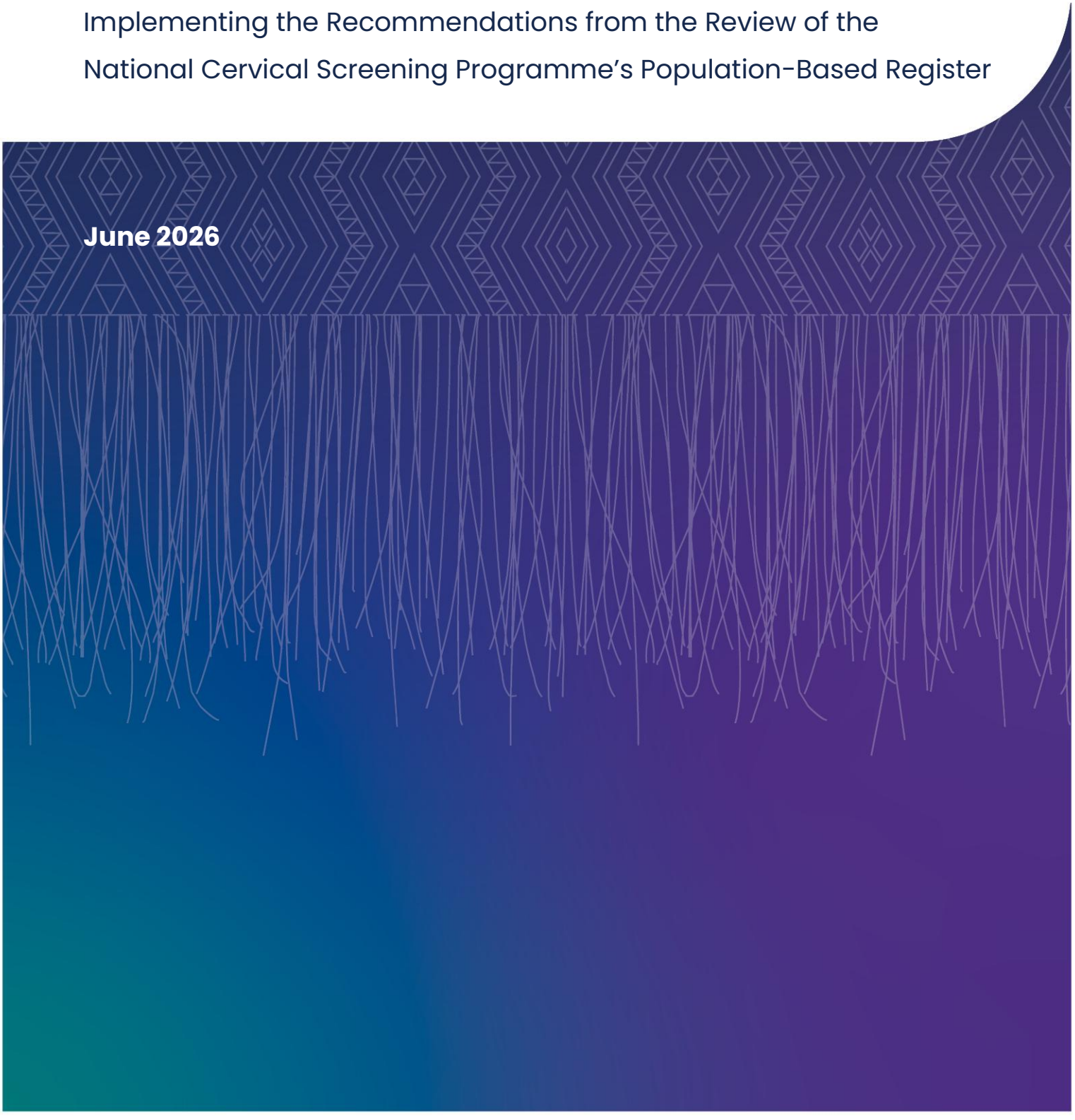
Health New Zealand
Te Whatu Ora

NCSP Population-Based Register Review Action Plan

Implementing the Recommendations from the Review of the National Cervical Screening Programme's Population-Based Register



June 2026

Citation: Health New Zealand | Te Whatu Ora. 2026. *NCSP Population-Based Register Review Action Plan*. Wellington: Health New Zealand | Te Whatu Ora.

Published in August 2026 by Health New Zealand | Te Whatu Ora
PO Box 793, Wellington 6140, New Zealand

ISBN 978-1-991139-74-0 (online)

Health New Zealand
Te Whatu Ora

This document is available at **healthnz.govt.nz**

Contents

Executive Summary

Health New Zealand | Te Whatu Ora (Health New Zealand) is responsible for delivering cervical screening, HPV immunisation, and treatment services in Aotearoa New Zealand, and is committed to the equitable elimination of cervical cancer. This aligns with the World Health Organization's (WHO, 2020) Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem, which is built on three pillars: vaccination, screening, and treatment.

Cervical cancer screening is a key preventative health measure that reduces the number of people developing, and dying from, cervical cancer each year. In September 2023, the National Cervical Screening Programme (NCSP) transitioned to human papillomavirus (HPV) screening, replacing Liquid Based Cytology as the primary screening test. At the same time, the NCSP Population-Based Register (the Register) was introduced to strengthen invitation, follow-up, and monitoring across the screening pathway.

In March 2024, following identified concerns relating to notification processes, pathway monitoring, governance, and system functionality, Health New Zealand commissioned an independent expert review of the Register.

The Review of the National Cervical Screening Programme's Population-Based Register (Health New Zealand, 2025b) (the Register Review) found that, while the Register is functioning well in many areas, improvements are required to strengthen clinical safety, governance, operations, digital capability, equity, and long-term sustainability. A total of 48 recommendations were issued.

In response to the priority recommendations, immediate clinical safety assurance and remediation activity was undertaken. This included increasing clinical case review capacity, review of safety-net monitoring processes, and ongoing work to examine the clinical implications of delays that have occurred, and whether these may have caused harm through a delayed diagnosis.

This NCSP Population-Based Register Review Action Plan (the Action Plan) sets out how the recommendations will be implemented through three integrated workstreams. These workstreams focus on addressing the underlying issues that contribute to multiple recommendations, enabling clearer prioritisation, stronger clinical oversight, and more sustainable delivery.

Implementation will be phased over two years. Work is already underway to strengthen clinical safety, monitoring, governance, and operational foundations, with progress monitored through established governance and reporting processes.

Background

About the NCSP

Within Health New Zealand, the National Public Health Service (NPHS) delivers the NCSP. The programme contributes to Aotearoa New Zealand's progress toward the equitable elimination of cervical cancer, consistent with the WHO (2020) Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem.

Cervical cancer screening is a key preventative health measure that reduces the number of people developing, and dying from, cervical cancer each year. Screening and follow-up detect and treat pre-cancerous changes to the cervix and, alongside HPV immunisation, help prevent cervical cancer.

In September 2023, the NCSP transitioned to HPV Primary Screening, replacing Liquid Based Cytology, commonly known as the smear test, as the primary cervical screening test. This change supports earlier detection of higher-risk HPV types and a more effective, evidence-based screening pathway.

About the NCSP Register

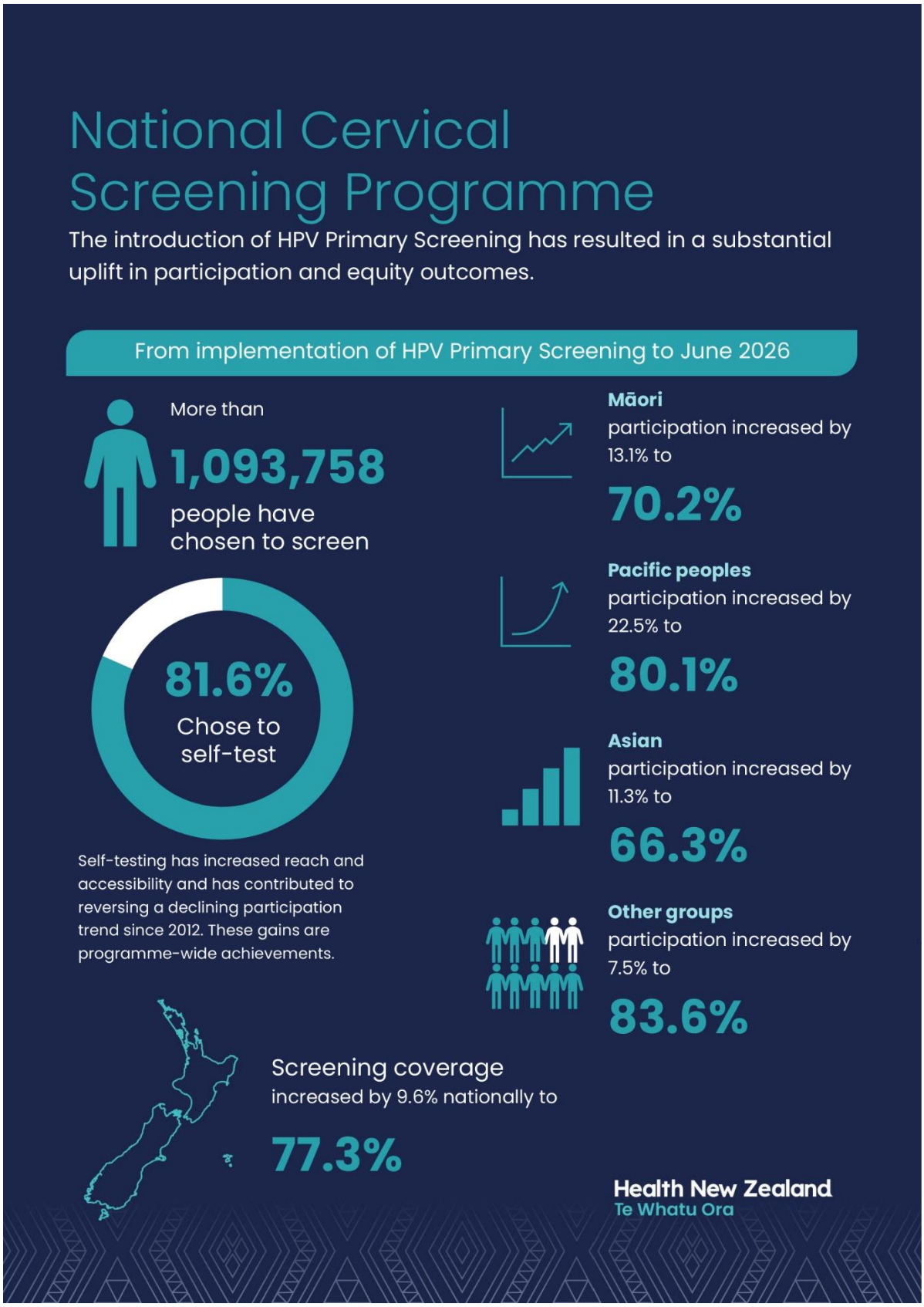
The NCSP Register was introduced to support the transition to HPV Primary Screening. It functions as a comprehensive screening management system, enabling a more coordinated approach across the screening pathway and improving the programme's ability to reach and support priority populations.

The Register supports delivery of the NCSP through:

- programme invitation
- screening pathway management
- participant follow-up
- pathway safety monitoring
- communication with eligible people
- programme performance reporting

Since the introduction of HPV Primary Screening, there has been a substantial uplift in participation in the NCSP and equity outcomes, as shown in Figure 1.

Figure 1: NCSP coverage and equity measures – September 2023 to June 2026



Data Source: Health New Zealand (2026).

The WHO (2020) strategy to eliminate cervical cancer is built on three key pillars and the 90–70–90 targets to be met by 2030:

1) Vaccination: 90% of girls fully vaccinated with the HPV vaccine by age 15
2) Screening: 70% of women screened using a high-performance test by ages 35 and 45
3) Treatment: 90% of women with pre-cancer treated, and 90% of women with invasive cancer managed

Together, these targets provide a clear pathway for countries to progress toward the long-term elimination of cervical cancer.

About the NCSP Register Review

Following the implementation of the Register, concerns were identified within Health New Zealand relating to notification processes, pathway monitoring, governance arrangements, and system functionality.

In response, Health New Zealand commissioned an independent review to assess the clinical safety and operational integrity of the Register.

A multidisciplinary expert review panel was appointed to undertake the review, chaired by Professor Marion Saville, Executive Director, Australian Centre for the Prevention of Cervical Cancer.

The purpose of the review was to assess the clinical safety and quality of the Register, including:

- whether implementation aligns with the intended design, and what can be learned from the implementation process
- current functionality, including whether participants receive timely and effective notifications, and whether screen-detected abnormalities are appropriately identified
- monitoring, audit, and reporting capabilities
- the ability of the Register to adapt to future requirements

The clinical safety and quality of the Register across these areas directly supports the ability of the NCSP to deliver an equitable screening programme and meet its Te Tiriti o Waitangi responsibilities.

The review panel found that, while many aspects of the Register are operating well, improvements are required to strengthen clinical safety monitoring, governance, operational processes, system functionality, equity performance, and long-term sustainability.

The Register Review issued 48 recommendations across these areas.

About the Health New Zealand response to the Register Review

In response to the priority recommendations from the Register Review, Health New Zealand undertook immediate clinical safety assurance and remediation activity. This included increasing clinical case review capacity, review of safety-net monitoring and adverse event management processes, and ongoing work to examine the clinical implications of delays that have occurred, and whether any delays may have caused harm through a delayed diagnosis. These actions will continue to support both harm detection and prevention.

Health New Zealand has developed an Action Plan to implement the recommendations through three integrated workstreams that focus on the underlying issues they address. This supports coordinated implementation, reduces duplication, and strengthens system-wide improvement.

Work to implement the Action Plan is progressing, with priority actions focused on clinical oversight, strengthened governance, improved communications, and system capability. Implementation will be phased over the next two years and informed by clinical safety, equity priorities, and technology considerations.

Progress will be tracked through established governance and monitoring processes, with updates provided through appropriate reporting channels. Participant privacy and responsible stewardship of public resources remain central throughout implementation.

This Action Plan sets out how those recommendations will be implemented.

Our Response

Principles for delivery

Health New Zealand is implementing the Register Review recommendations to strengthen clinical safety, improve participant experience, advance equity, and support sustainable system performance.

Implementation of the recommendations is guided by our statutory obligations, including ensuring that the NCSP meets its Te Tiriti o Waitangi responsibilities, and our commitment to continuous quality improvement.

Clinical safety first

Actions are prioritised to reduce participant risk and ensure people safely move through the screening pathway by strengthening monitoring, follow-up, and assurance mechanisms.

Equity by design

Improvements are designed to increase participation, strengthen follow-up, and improve outcomes for Māori, Pacific peoples, and other underserved communities.

Collaborative governance

Clinical, operational, and digital expertise guide implementation, with clear accountability for delivery and oversight of risks.

Privacy and legislative compliance

All changes meet legal and ethical obligations, including requirements under the Health Act 1956 (Part 4A). Participant privacy, appropriate data use and information security remain central.

Transparency with care

Progress will be communicated through clear, accessible updates, while ensuring participant confidentiality and responsible stewardship of public resources.

Our approach

Implementation of the Register Review recommendations is being progressed through three integrated workstreams, supported by clinical leadership and governance.

The recommendations have been grouped according to the underlying issues they address. This approach ensures that improvements resolve root causes, strengthen system performance, and support safe and consistent delivery across the screening pathway.

The three workstreams are:

1) System Integrity, Data and Integration
2) Service Delivery and Operating Model
3) Clinical, Quality and Monitoring

Each workstream brings together related actions and is supported by clinical oversight to ensure decisions are informed by participant safety, clinical evidence, and equity impact.

The phased delivery approach will allow work to be sequenced in line with clinical priorities, system readiness, and available resources.

How this aligns with our quality framework

The improvements set out in this Action Plan align with the four domains of the NPHS Quality Framework (Health New Zealand, 2025a). These domains are:

1) Communities and whānau are active partners
2) Engaged, effective and culturally safe workforce
3) System safety and learning
4) Keeping communities well through knowledge-informed practice

This framework describes what high-quality public health practice looks like. It emphasises equity, continuous learning, and ensuring that programmes contribute to Pae Ora.

In practice, this means the changes to the Register strengthen clinical safety, support community partnership, build workforce capability, and enable knowledge-informed decision-making.

Our key areas of focus

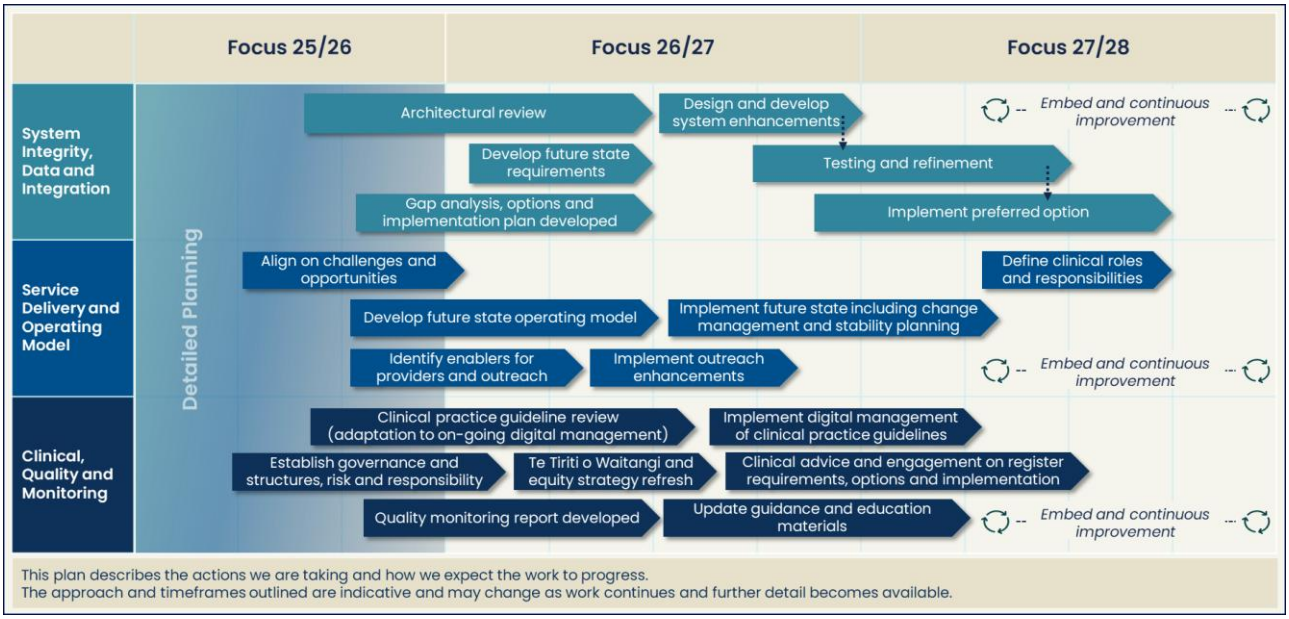
Table 1 outlines the focus of each workstream, the improvements being delivered, and how these contribute to strengthening quality and safety across the Register and the wider NCSP.

Figure 2 provides an indicative overview of workstream progression over time.

Table 1: Workstream focus areas

Workstream	Focus	What this will improve	How this strengthens quality and safety
WS-1: System Integrity, Data and Integration	Strengthening the reliability, functionality, and long-term sustainability of the Register and supporting systems, including data quality, system integration, and clinical rules.	A system that is accurate, reliable, and able to adapt as clinical guidance, research, evidence, and programme needs change. Improved visibility of screening pathways and reduced reliance on manual workarounds.	Reduces the risk of incorrect pathways, missed follow-up, or inconsistent information. Improves confidence in data quality and supports safe, evidence-based screening and follow-up. *(Aligns to NPHS Quality Framework Domain 3 and Domain 4)*
WS-2: Service Delivery and Operating Model	Improving how screening services are delivered across the system, including operating models, provider support, communications, and workforce capability.	More consistent and coordinated service delivery, clearer roles and responsibilities, and improved access to information for providers and participants. Supports more flexible communication channels for participants.	Improves equitable access to screening and follow-up, reduces variation in service delivery, and supports timely and appropriate care. *(Aligns to NPHS Quality Framework Domain 1 and Domain 2)*
WS-3: Clinical, Quality and Monitoring	Strengthening clinical safety, pathway assurance, monitoring, and continuous improvement, including follow-up processes, harm detection, and governance.	Earlier identification of risk, stronger safeguards for follow-up, improved incident management, and more consistent monitoring and reporting.	Strengthens clinical oversight and programme assurance, supports early identification and response to issues, and embeds continuous learning across the system. *(Aligns to NPHS Quality Framework Domain 3 and Domain 4)*

Figure 2: Indicative workstream timeline



Our Progress

Implementation of the Register Review recommendations is firmly underway, with delivery now moving at pace.

In 2025/26, the programme has and will continue to be focused on executing targeted actions to strengthen clinical safety, embed robust monitoring, and put in place the operational discipline required for consistent, system-wide implementation.

Delivery is focused on the following priority actions:

Clinical safety and monitoring

- Completing targeted clinical case reviews to validate participant pathways and drive immediate corrective actions where required.
- Strengthening safety-net monitoring and embedding more rigorous adverse event identification, escalation, and response processes.
- Establishing and operationalising an enhanced monitoring framework to provide ongoing, system-level oversight and assurance.

Transparency and accountability

- Producing the first peer-reviewed monitoring report following the transition to HPV Primary Screening, strengthening system transparency and independent assurance.

Operational foundations

- Embedding strengthened governance arrangements with clear decision-making authority and accountability.
- Implementing structured risk and issue management processes to enable proactive management and timely escalation.

Impact

- These actions are materially strengthening clinical oversight, improving visibility of system performance, and lifting the discipline required to deliver safely at scale.

Next phase

- With these foundations in place, the programme is now positioned to accelerate coordinated implementation of the remaining recommendations, with a clear focus on consistency, pace, and measurable system impact.

Next steps

As implementation progresses over the next two years, the focus will increasingly shift toward strengthening the overall capability and resilience of the Register and the screening pathway.

This includes enhancing digital and technology foundations, improving how participants move through the screening pathway, and ensuring governance and operational settings support safe, equitable, and sustainable delivery.

Future phases of work will be sequenced in line with clinical, quality, and safety priorities, system readiness, and available resources. This approach supports long-term performance, adaptability, and continuous improvement.

Monitoring and reporting

Implementation of the Register Review recommendations is supported through strengthened monitoring and established joint governance arrangements.

Progress will be tracked by focusing on the issues being addressed, supported by workstream reporting and recommendation-level tracking for assurance purposes. This ensures that progress reflects resolution of underlying issues, alongside addressing individual recommendations.

Reporting will provide visibility of delivery confidence, risks, dependencies, and improvements in clinical safety and programme performance. Risks and issues will be actively managed and escalated through governance structures where required.

Updates on progress will be communicated through established reporting channels, with public reporting provided where appropriate. Participant privacy and data security remain central to all monitoring and reporting activity.

Appendix 1

Register Review recommendations

The independent Review of the National Cervical Screening Programme's Population-Based Register (Health New Zealand, 2025b) made 48 recommendations to strengthen the safety, functionality, governance, and equity performance of the Register and the wider programme.

The recommendations were issued in two phases:

1) Four priority recommendations (February 2025 interim findings)
2) Additional high and secondary priority recommendations (February 2026)

These recommendations cover improvements to:

- clinical follow-up and pathway safety
- safety-net monitoring and harm detection
- notifications and communication processes
- Register functionality and system controls
- governance and risk management
- equity alignment
- provider tools and data flows
- workforce capability and education

Each recommendation is mapped to one of the three workstreams to support implementation through:

- clear accountability
- logical sequencing
- coordinated implementation
- transparent tracking of progress

Implementation is supported through shared operational, clinical, and digital expertise to ensure recommendations are delivered safely and sustainably, and priority given to actions that strengthen clinical safety and equitable outcomes.

Table 2 lists all recommendations from the Register Review and the workstream each is aligned to. The mapping reflects the delivery approach at the time of publication and may change as implementation progresses to support more effective resolution.

Table 2: Register Review recommendations and workstreams

#	Register Review recommendation	Workstream
Priority recommendations – February 2025		
RR-I	An action plan is developed that documents issues that need to be addressed, prioritises these issues, identifies appropriate actions to mitigate/fix, an accountable role, and a timetable for completion of each action.	**WS-3** Clinical, Quality and Monitoring
RR-II	Increase staffing resources allocated to individual case reviews, to expedite their resolution.	**WS-2** Service Delivery and Operating Model
RR-III	Prioritise the pathway status safety work being initiated and supplement it with additional resources to ensure it can be completed as quickly and effectively as possible.	**WS-3** Clinical, Quality and Monitoring
RR-IV	Consider how staffing resources can be protected and strengthened to support the NCSP to operate and maintain a safe population-based register.	**WS-1** System Integrity, Data and Integration; and **WS-2** Service Delivery and Operating Model
Additional high priority recommendations – February 2026		
RR-1	Register functionality to flag unscreened and under screened individuals needs to be built. This will allow for appropriate clinical prioritisation of individuals overdue for screening and to meet reporting requirements. The first step will be for the NCSP clinical team and Digital Services to review definitions and then develop technical requirements. The NCSP clinical team should review these to ensure they will meet clinical requirements. If the ICT vendor advises this functionality cannot be developed quickly, an interim workaround should be explored. It should be considered if it would be possible to use screening data warehouse information to identify unscreened and under screened individuals and for this designation to then be uploaded to the Register to allow for flags to be created.	**WS-1** System Integrity, Data and Integration
RR-2	Ensure there is appropriate follow-up for screen detected abnormalities. Given the Register does not have access to complete screening histories for all participants and so may not always be able to determine the appropriate next expected event, additional work is required to review participants with complex histories, including previous high-grade results or other persistent HPV infections, to ensure they are on the correct clinical pathway. This will require reporting outside of the Register to identify relevant individuals based on their screening history. Failure to do so poses a significant risk to affected individuals, potentially leading to delayed diagnosis or treatment and so proactive measures must be taken to safeguard patient outcomes.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring

#	Register Review recommendation	Workstream
RR-3	The NCSP and Digital Services should develop an action plan to address all the issues identified by the notification review, which have not yet been resolved. This should record all ongoing remediation, actions identified in the notification review action tracker, actions to address the relevant recommendations in this report, and any other actions identified as being required. Actions should be prioritised according to clinical risk and thereafter impact on the effectiveness of the programme. This action plan should incorporate advice from the ICT vendor on timeframes to implement solutions. This action plan should be presented regularly to a relevant governance group, and a summary should be included in weekly remediation email updates to ensure visibility.	**WS-3** Clinical, Quality and Monitoring
RR-4	'Cohorting' functionality should be phased out to ensure all eligible individuals receive cervical screening notifications. While cohorting was an appropriate transition measure to protect cervical screening services and promote equity, it should not be continued indefinitely, in line with the original intentions of the notification strategy. The review panel advises that the first step should be disabling cohorting for high priority recall notifications, followed by other recall notifications and finally any eligibility notifications not currently being sent.	**WS-1** System Integrity, Data and Integration
RR-5	The Register's notification functionality needs to include being able to initiate text message and email communication. The Register should include a record of individual communication preferences. Small scale pilots being carried out should inform the development of full-scale functionality, with implementation as soon as possible.	**WS-1** System Integrity, Data and Integration
RR-6	Support to Screening (SSS) task management functionality should be built to allow for follow up tasks to be centrally coordinated and overseen. The volume of tasks likely to require management will need to be assessed and that Support to Screening services match this expected level of demand (see recommendation 12). It may make sense to trial task functionality this with one Support to Screening service first, to ensure the functionality is working as intended and gather feedback from users about whether usability functionality needs to be improved prior to wider rollout.	**WS-2** Service Delivery and Operating Model
RR-7	Early reminder for priority population functionality should be rebuilt. Early reminder tasks should be created for Support to Screening services at two months with a routine reminder sent at three months if screening has not taken place. This should be deployed once Support to Screening capacity has been addressed, and tasks are in place.	**WS-2** Service Delivery and Operating Model
RR-8	The design of solutions to address ongoing Register issues and to implement new clinical guidelines needs to learn lessons from the implementation of the Register. If it has not already been conducted a formal reflective exercise incorporating all relevant perspectives (clinical, technical, and operational teams) should be undertaken. This reflective learning exercise may also provide valuable lessons which would benefit	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring

#	Register Review recommendation	Workstream
	other Prevention initiatives including other screening Programmes. The exercise should include exploring: • Improving the capture of clinical requirements and communication to the design of technical solutions. • Those designing technical solutions must have a firm understanding of the intention of clinical guidelines, as well as the documented requirements, to ensure solutions meet these intentions. • Feedback and collaboration to address requirements not considered to be technically or operationally feasible. • Ongoing clinical input in the design and development of technical solutions. • Joint clinical, technical, and operational sign-off of designed solutions before they are finalised, to confirm that the intended result has been achieved. • Robust testing, by the ICT vendor, Digital Services, and by end users of the solutions prior to deployment to prevent issues from arising. • A robust safety-net, including operational monitoring, being designed and prepared with clinical input to be put in place at go-live to ensure the solutions implemented are safe, effective, and meet requirements.	
RR-9	Catch-up batches of unsent notifications must be sent as soon as possible. To inform how these notifications are sent, the NCSP and Digital Services must carry out a realistic appraisal of how soon email and text message notification functionality can send large volumes of notifications. If this will not be possible soon, funds should be found to ensure notifications are sent by mail without any further delay. The NCSP should consider whether an explanation about the delay of these notifications should be included when they are sent. These notifications should be prioritised based on a clinical risk assessment considering: • individuals' history of abnormal results and those on a higher risk pathway. • the screening history of those affected. • which types of notifications are most significant. • how long the notifications have been overdue. • whether individuals are members of priority populations.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-10	The NCSP should conduct a root cause analysis of samples of recent laboratory recommendation mismatches and colposcopy clinic rejection messages. This will help to determine what the major contributing factors of these issues are. This should be supported by Prevention quality resources to bring additional expertise and capacity.	**WS-1** System Integrity, Data and Integration
RR-11	The pathway safety net project should include the root cause analysis of individuals identified by reporting as having fallen through existing safety nets. This should explore the reasons why this has occurred, whether the underlying issue may have affected other individuals not yet identified, and what can be done to strengthen safety nets to prevent similar issues from	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical,

#	Register Review recommendation	Workstream
	occurring. As new safety net processes are designed and implemented, ongoing reporting will be required to demonstrate that safety is being improved and the need for root cause analysis is decreasing.	Quality and Monitoring
RR-12	The NCSP should publish an independently peer reviewed monitoring report as soon as possible. The publication of this report is important to ensure sector visibility of the impact of the new HPV programme. It is likely that, to ensure this deadline is met, dedicated screening intelligence resources are required. The review panel advises that monitoring report indicators should be analysed by prioritised ethnicity, rural/urban status, and sex assigned at birth. The NCSP should also explore how to report on indicators for other prioritised groups identified in its equity strategy, i.e., based on LGBTQI+ and disability status. Preparation of this report should involve consultation with the National Kaitiaki Group (NKG).	**WS-3** Clinical, Quality and Monitoring
RR-13	The NCSP should progress Support to Screening service contract arrangements. This process should ensure that adequate services are available across the country and that contracts are long enough to allow for permanent staff to be recruited. It is acknowledged that these services are shared with BreastScreen Aotearoa and Hauora Māori Services and therefore joint discussions are required to progress this action.	**WS-2** Service Delivery and Operating Model
RR-14	Participants should only be classified as 'under specialist care' in appropriate circumstances with tasks monitored to ensure they are actioned. The review panel would suggest that a clear definition of this term, perhaps limited to where a sample is taken in a colposcopy clinic, is provided in SOP documents and shared through clinical education. The Register should not allow these tasks to be closed without appropriate reason and there should be monitoring of whether tasks are managed appropriately.	**WS-3** Clinical, Quality and Monitoring
RR-15	The NCSP should document and communicate who has clinical responsibility for each stage of participants' screening journey. This should include different scenarios for processes including invitation and recall for screening and management of positive results. Consideration should also be given to how these lines of responsibility may change if the Register is to take a more central role in invitation, recall and reminder, and potentially direct referral to colposcopy, in the future.	**WS-3** Clinical, Quality and Monitoring
RR-16	The NCSP's operational and clinical teams and Digital Services should work collaboratively to develop and document a shared Register governance process. This should include defined roles and responsibilities related to the Register, escalation pathways, and decision-making processes, which should include all three parties. There should be clinical input to all key decisions about Register functionality, including prioritisation and production planning of functionality development.	**WS-3** Clinical, Quality and Monitoring
RR-17	There should be a single, unified process for identifying, documenting, assessing risks and issues. If the current Prevention level template for documenting Register risks and issues is used, there should be Digital	**WS-3** Clinical, Quality and Monitoring

#	Register Review recommendation	Workstream
	Services input into this to ensure all risks and issues are visible in one place. There should also be shared processes for planning actions to mitigate/resolve risks and issues, prioritisation of actions, and monitoring and holding accountability for progress in implementing these actions. There must be clinical oversight of actions to address issues that pose clinical risk.	
RR-18	Quality monitoring for laboratory messages, screen takers, and colposcopy clinics should be developed, to ensure that the programme is operating as expected. Recently implemented HPI information should facilitate this to be done.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-19	There should be ongoing monitoring for harms associated with the NCSP. This is particularly important given the issues associated with the implementation of the new Register. If it is determined that individuals have come to harm and that deficiencies in the way that screening has been offered or provided, including related to the Register, may have contributed to this, appropriate disclosure, apology, and explanation should be provided. Monitoring should include identifying if individuals with cervical cancer were: • not invited to be screened, • not recalled or reminded, • not followed up when reminded to be screened, • delayed in receiving a cancer diagnosis after an abnormality was detected, screened, but abnormalities were not detected.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-20	Unnecessary barriers to clinical staff gaining access to Whaihua should be removed. This should include removing the requirement for specialist gynaecologists to do online HPV training prior to being given access.	**WS-2** Service Delivery and Operating Model; and **WS-3** Clinical, Quality and Monitoring
Additional secondary priority recommendations – February 2026		
RR-21	The interface between laboratory information systems and the Register should be re-thought. Any solution should ensure the information laboratories hold is also considered when assessing potential mismatches. Given there are a small number of laboratories undertaking this testing and their staff are subject matter experts, if there is a mismatch then a pathway to harmonise the information and recommendation is needed. It should be explored whether it is possible to develop a solution that provides laboratories with clinical guideline driven suggested recommendations or rapid and direct feedback on recommendations mismatches.	**WS-1** System Integrity, Data and Integration

#	Register Review recommendation	Workstream
RR-22	The NHI active rule should be amended or eliminated to ensure notifications are sent appropriately. This rule should either be amended to the six-year timeframe originally intended, to match the cervical screening interval, or eliminated and catch-up notifications sent. The review panel noted that once email notifications can be sent, the NHI active rule may no longer be required. Using email eliminates the cost and privacy implications of sending letters to individuals who may no longer be in the country or living at the recorded address. Sending email notifications to inactive individuals may help to determine if they need screening or if they would wish to opt out of screening either temporarily while they are away, or indefinitely.	**WS-1** System Integrity, Data and Integration
RR-23	Upgrade all districts to the latest version of Gynaecology Plus. This will help eliminate rejection messages and thereby reduce the number of colposcopy clinic tasks. This will have an up-front cost but should produce savings in the form of reduced Register Central Team and colposcopy clinic staff time. To make the case for funding to be allocated to upgrades, a cost-benefit analysis could be undertaken to quantify potential savings.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-24	A technical solution should be found to ensure immunocompromised status is communicated to the Register from laboratory information systems, where this information is available on the laboratory form.	**WS-1** System Integrity, Data and Integration
RR-25	Implementing primary care access to screening histories needs to learn lessons from the implementation of the Register. This includes: • Performing robust testing by the ICT vendor, Health New Zealand Digital Services, and by selected end-users of the solution prior to deployment to prevent serious issues, such as the out of sequence histories that affected the Register post-implementation, which could undermine primary care confidence in the NCSP. • Listening to feedback from pilot practices and acting on this to ensure that the solution implemented meets the needs of users.	**WS-2** Service Delivery and Operating Model
RR-26	The NCSP should issue updated guidance to screening providers on how to effectively capture details of individuals' ethnicity, gender, and sex assigned at birth and have these recorded in the Register. This should include an explanation of why this is important to cervical screening. The NCSP should ensure that the process for having updated information recorded in the Register is easy for providers to follow to encourage this to be done consistently.	**WS-1** System Integrity, Data and Integration
RR-27	The Register test plan should be reviewed and improved as required. This should take account of learning from the recent HPI incident and why the underlying issue was not identified in testing.	**WS-1** System Integrity, Data and Integration; and **WS-2** Service Delivery and Operating Model

#	Register Review recommendation	Workstream
RR-28	The NCSP should revisit its decision to not include negative results from HPV studies that used a test that was not validated at the time but is now validated for use in New Zealand. Both positive and negative tests from these studies should be used to inform pathways and the study results displayed in the Register. This is important because the WHO recommends screening no more frequently than every five years because HPV infections detected so soon after a negative test are very unlikely to be associated with significant disease and in this scenario, the harms of screening are likely to outweigh the much lower benefits associated with early rescreening. They will also have a systemic impact through unnecessary referral to colposcopy at a time where these services are already stretched.	**WS-1** System Integrity, Data and Integration
RR-29	Develop operational reporting of the rates of completed notifications, which can identify if there are significant gaps. This will help to identify any lasting or new technical issues preventing notifications from being sent. This reporting should be managed by the Register Central Team and shared with the NCSP's clinical and operational teams to ensure they have the necessary oversight of the programme. This reporting should include a breakdown by priority groups identified in the equity strategy.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-30	Operational Register reporting that is contingent on previous screening history needs to be supplemented with reporting from the screening data warehouse. This includes any reporting that needs to identify high risk individuals who are overdue for screening or a next expected event. This additional reporting may necessitate additional screening intelligence resources. In the long term, it should be considered if it is more efficient to migrate screening histories to the Register, to allow for this reporting to be done within the Register.	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-31	The NPHS and Digital Services must critically assess the long-term viability of the Register and the underlying NSS to support the NCSP. This should be informed by feedback from the ICT vendor about the possibility, timeframes for, and costs of implementing the functionality these recommendations call for. This assessment should also include consideration of whether the Register can effectively and efficiently implement clinical guidelines changes. If this assessment determines that the required functionality cannot be implemented, a risk-assessment should be undertaken of procuring a new software solution in the long term rather than continuing with the Register and NSS. This assessment should also include reviewing the contract in place with the ICT vendor to determine what of the outstanding functionality that requires further development is covered by the work that was contracted and what work will require additional funding. Advice from Health New Zealand legal should be sought as required.	**WS-1** System Integrity, Data and Integration
RR-32	Once notification functionality is working as intended, the NCSP should clearly communicate the role of primary care in notifying enrolled participants. This should be informed by discussion with the primary care sector to ensure there is a unified vision of the best way to achieve the	**WS-2** Service Delivery and Operating Model; and

#	Register Review recommendation	Workstream
	NCSP's goals of eliminating cervical cancer. There should be ongoing discussion with the primary care sector to determine, a long-term vision for the role of central invitation, engagement, and self-testing (including the sending of self-testing kits). This will help to guide the long-term planning of the requirements for a cervical screening population-based register.	**WS-3** Clinical, Quality and Monitoring
RR-33	Adverse event management processes should explore if there are root causes that include deficiencies in the Register's functionality and/or supporting processes. Adverse event management should be supported by a dedicated quality resource that brings additional capacity and expertise to ensure that investigations are comprehensive.	**WS-3** Clinical, Quality and Monitoring
RR-34	The NCSP should work with NKG to investigate the decrease in applications for data to the NKG. This should explore if there are any systemic barriers contributing to this, which need to be addressed.	**WS-3** Clinical, Quality and Monitoring
RR-35	NCSP education materials should be revised and/or developed to improve the accuracy of pathway management. This should include revising screen taker education materials to ensure they provide clear instructions on capturing immunosuppressed status. The need for additional education materials, e.g., for laboratory or colposcopy clinic staff should be informed by the findings of the root cause analysis of recent laboratory recommendation mismatches and colposcopy clinic rejection messages (see recommendation 9).	**WS-1** System Integrity, Data and Integration; and **WS-3** Clinical, Quality and Monitoring
RR-36	The NCSP should develop policies and procedures for follow-up of individuals overdue for screening or subsequent clinical assessment and testing. These should set out responsibilities and expectations any follow up to be conducted by the Register Central Team, Regional Coordinators, and Support to Screening services.	**WS-1** System Integrity, Data and Integration; and **WS-2** Service Delivery and Operating Model
RR-37	The NCSP should finalise and publish its Te Tiriti o Waitangi and Equity Strategy. Once finalised, it should consider whether the programme is currently in alignment with this strategy. If any gaps are identified, outside of those already identified by this review, actions to address these gaps should be developed.	**WS-3** Clinical, Quality and Monitoring
RR-38	Rules for sending unenrolment communications should be reviewed. It should be ensured that anyone being unenrolled is sent this communication, including any transgender and non-binary individuals being unenrolled due to their sex at birth.	**WS-1** System Integrity, Data and Integration
RR-39	The NCSP should confirm if Whaihua users have access to the necessary functionality to undertake their roles. This includes laboratory, colposcopy clinic, and Support to Screening service users. Functionality available should include updating demographic and contact information and reporting participants with an incorrect pathway status. Changes to levels of access, permission to edit fields, and/or user education may be required to address issues. If Whaihua users cannot complete necessary tasks, and	**WS-2** Service Delivery and Operating Model

#	Register Review recommendation	Workstream
	this functionality cannot be added to Whaihua, direct Register access may be necessary for some types of users.	
RR-40	There should also be a regular venue for discussion of long-term requirements of a cervical screening population-based register. This should involve clinical, technical and operational perspectives. This should lead to a multi-year plan including forward planning for future clinical guideline changes and other new functionality requirements.	**WS-1** System Integrity, Data and Integration
RR-41	Consult with private colposcopy clinics on them moving to the use of a software-based process to submit data to the Register. The NCSP may wish to consider making this a requirement of being a screening provider in the long term.	**WS-1** System Integrity, Data and Integration
RR-42	The NPHS and Digital Services should review how key product documents are stored. The review panel was concerned that some key documents may only be stored in an environment controlled by the IT vendor. This may have implications for Health New Zealand's access to this documentation and its ability to meet requirements such as fulfilling Official Information Act requests. The learning from this may have wider implications for other Health New Zealand digital products.	**WS-1** System Integrity, Data and Integration
RR-43	The NCSP should work towards gathering data to meet the requirements of, and submit data to, the World Health Organisation's Cancer Screening in Five Continents (CanScreen5) project	**WS-3** Clinical, Quality and Monitoring
RR-44	The NPHS should communicate with the Cervical Screening Parliamentary Review Committee and the Ministry of Health's Public Health Agency about implementing these recommendations in line with wider action plans for cervical screening.	**WS-3** Clinical, Quality and Monitoring

Recommendations Source: Health New Zealand (2025b).

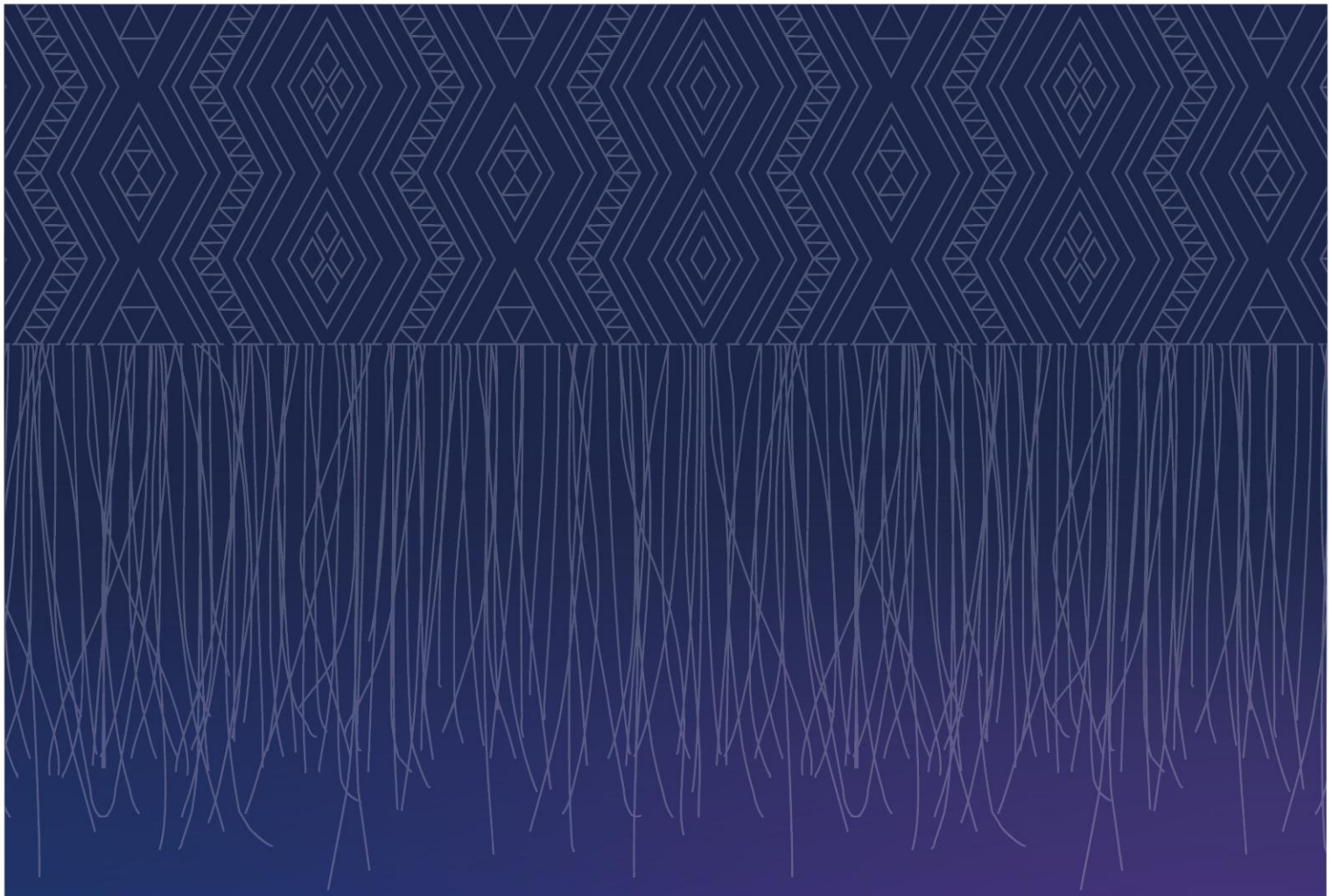
References

Health New Zealand | Te Whatu Ora. (2025a). *Quality framework: National Public Health Service* [Internal document].

Health New Zealand | Te Whatu Ora. (2025b). *Review of the National Cervical Screening Programme's population-based register*. https://www.healthnz.govt.nz/publications/review-of-the-national-cervical-screening-programmes-population-based-register

Health New Zealand | Te Whatu Ora. (2026). *National Cervical Screening Programme interactive coverage data tool*. https://tewhatuora.shinyapps.io/nsu-ncsp-coverage/

World Health Organization. (2020). *Global strategy to accelerate the elimination of cervical cancer as a public health problem*. https://www.who.int/publications/i/item/9789240014107



Health New Zealand
Te Whatu Ora